Ku Jia Shiuen (an infant suing through her mother and next friend, Tay Pei Hoon) & Anor v Government of Malaysia & Ors

HIGH COURT (JOHOR BAHRU) — SUIT NO 21–21 OF 2009
VERNON ONG J
31 DECEMBER 2012

Tort — Negligence — Medical negligence — Whether doctors negligent in causing baby to develop cerebral palsy — Whether baby should have been delivered by caesarean section — Whether congenital knee deformity in mother made her unable to deliver in lithotomy position — Whether mother's first delivery should have been done in hospital's labour ward rather than at midwife-run birthing centre — Whether oral evidence of nurses and doctors involved in delivery conflicted with contemporaneous documents and was unreliable

The second plaintiff ('Tay') delivered the first plaintiff ('KJS'), now a 9 1/2-year-old girl, at the Birthing Centre ('BC') in the grounds of the Sultan Aminah Hospital in Johor Bahru at which hospital the third defendant, then a registrar, and the fourth defendant, then a houseman, worked. It was Tay's first pregnancy and according to the policy of the Ministry of Health she should have been admitted to the hospital's labour ward, where there were specialists, instead of to the BC which was run by midwives who would only call in a medical officer if complications arose. As it turned out, Tay did encounter complications. She had a prolonged second-stage labour as she had difficulty pushing the baby out largely because she was incapable, due to a congenital deformity, of bending her right knee and therefore should not have been required to give birth in the lithotomy position. The midwives summoned the fourth defendant who, in turn, asked the third defendant ('Dr Faizal') to assist. Finding that there was a case of 'fetal distress with poor maternal effort and prolonged second-stage labour', Dr Faizal performed a vacuum-assisted delivery. The condition of KJS was poor at birth as she suffered respiratory distress syndrome. The baby was resuscitated and sent with oxygen ventilation to the intensive care ward ('NICU') in the hospital's paediatric unit for 10 days before being discharged. However, due to the deprivation of adequate oxygen supply to the brain ('HIE') that KJS suffered during birth she ended up with a severe case of cerebral palsy rendering her totally dependent on others to take care of her for life. KJS suffered severe physical and mental retardation, had no chance of being educated or trained and faced a shortened life-span of between 30 and 35 years. The plaintiffs' expert witnesses testified that in the absence of evidence to the contrary there was very likely prolonged partial hypoxia (oxygen deprivation) during labour of least an hour that resulted in the

development of cerebral palsy in KJS. The records also showed that after birth there was an hour's delay in transferring KJS from the BC to the NICU and another 45 minutes before she was attended to by a medical officer there. All this delay coupled with the delay in diagnosing the baby's condition and administering treatment aggravated her already grave condition. In their instant suit against the defendants for damages for medical negligence, the plaintiffs contended that KJS's present disability and loss were caused by the defendants' failure during labour to prevent hypoxia and the consequent fetal distress, failure to provide suitable/qualified obstetrical and gynaecological care and failure to provide adequate and immediate after-care to the infant.

Held:

(1) The court was satisfied on balance of probabilities that the defendants were liable for the spastic quadriplegia secondary to HIE suffered by KJS. The defendants had failed to provide the appropriate immediate after-care, which delay contributed to aggravation of HIE and the development of cerebral palsy in KJS (see para 69(a) & (c)).

(2) As there were no qualified and suitable obstetricians and gynaecologists ('O & G') available at the BC, and as neither the third and fourth defendants were qualified O & G, the court agreed with the opinion of the plaintiffs' expert witness that KJS's delivery ought to have been performed under Caesarean Section due to Tay's congenital knee deformity and that she should have been admitted to the labour ward instead of to the BC where there were no qualified O & G at hand (see para 69(d)).

(3) The court found the oral evidence of the nurses and of the third and fourth defendants departed from the objective evidence and the contemporaneous documents and were accordingly unreliable. On the other hand, the evidence of the two expert witnesses called by the plaintiffs was credible, independent, unbiased and objective. They confined their opinion to the objective facts and contemporaneous documents and to the overall probabilities without attempting to misrepresent or mislead the court (see paras 65–66).

(4) The opinion of the defendant's expert witness, Dr Angeline, was not independent, objective or unbiased. There were glaring omissions and misrepresentations and she failed to consider all the material facts (see para 58).

[Bahasa Malaysia summary

Plaintif kedua ('Tay') melahirkan plaintif pertama ('KJS'), seorang budak perempuan yang sekarang ini berumur 9 1/2 tahun, di Pusat Kelahiran ('PK') di perkarangan Hospital Sultan Aminah di Johor Bahru, di hospital di mana defendan ketiga, pada masa itu seorang pendaftar, dan defendan keempat, pada

masa itu seorang doktor pelatih, bekerja. Itu merupakan kehamilan kali pertama Tay dan menurut polisi Kementerian Kesihatan, dia seharusnya dimasukkan ke wad bersalin hospital, di mana terdapat pakar-pakar, bukannya PK yang diuruskan oleh bidan-bidan yang hanya akan memanggil pegawai perubatan sekiranya komplikasi timbul. Didapati, Tay mengalami komplikasi. Dia mengalami kelahiran peringkat kedua yang berpanjangan memandangkan dia menghadapi kesukaran meneran bayi keluar yang sebahagian besarnya disebabkan dia tidak dapat berbuat demikian akibat kecacatan kongenital untuk melenturkan lutut kanannya dan oleh itu dia tidak seharusnya perlu melahirkan dalam kedudukan litotomi. Bidan-bidan memanggil defendan keempat, yang kemudiannya meminta defendan ('Dr Faizal') untuk membantu. Apabila mendapati bahawa ia merupakan kes 'fetal distress with poor maternal effort and prolonged second-stage labour', Dr Faizal menjalankan kelahiran secara bantuan vakum. Keadaan KJS adalah lemah memandangkan dia mengalami sindrom masalah pernafasan. Bayi tersebut dibangunkan dan dihantar dengan bantuan oksigen ke wad jagaan intensif ('WJI') di unit pediatrik hospital selama 10 hari sebelum dibenarkan keluar. Walau bagaimanapun, disebabkan kekurangan bekalan oksigen ke otak ('HIE') yang dialami KJS semasa dilahirkan, dia akhirnya mengalami kes *cerebral palsy* yang teruk, menjadikannya bergantung sepenuhnya kepada orang lain untuk menjaganya seumur hidup. KJS mengalami kecacatan fizikal dan mental yang teruk, tidak mempunyai peluang untuk diajar atau dilatih dan jangka hayat dipendekkan di antara 30 dan 35 tahun. Saksi-saksi pakar plaintif-plaintif memberi keterangan bahawa dalam ketiadaan keterangan berlawanan, terdapat kemungkinan besar hipoxia separa berpanjangan (kekurangan oksigen) semasa melahirkan kurang daripada satu jam, mengakibatkan perkembangan cerebral palsy dalam KJS. Rekod-rekod juga menunjukkan bahawa selepas kelahiran, terdapat sejam kelewatan untuk memindahkan KJS daripada PK kepada WJI dan 45 minit kemudian sebelum dia dirawat oleh pegawai perubatan di sana. Kesemua kelewatan ini ditambah dengan kelewatan mendiagnos keadaan bayi dan memberikan rawatan memburukkan keadaannya yang sememangnya teruk. Dalam guaman mereka ini terhadap defendan-defendan untuk ganti rugi bagi kecuaian perubatan, plaintif-plaintif menghujah bahawa kecacatan KJS sekarang dan kerugian diakibatkan oleh kegagalan defendan semasa kelahiran untuk menghalang hipoxia dan kesusahan janin yang timbul, kegagalan untuk memberikan pakar perbidanan yang sesuai/berkelayakan dan penjagaan sakit puan dan kegagalan untuk memberikan penjagaan selepas yang bersesuaian dan segera kepada bayi.

Diputuskan:

(1) Mahkamah berpuas hati atas imbangan kebarangkalian bahawa defendan-defendan bertanggungan untuk *spastic quadriplegia secondary to HIE* yang dialami oleh KJS. Defendan-defendan gagal untuk memberikan penjagaan selepas yang bersesuaian, di mana kelewatan

tersebut menyumbang kepada kemelaratan HIE dan perkembangan *cerebral palsy* dalam KJS (lihat perenggan 60(a) & (c)).

(2) Memandangkan tiada pakar perbidanan dan sakit puan berkelayakan dan sesuai ('O & G') yang ada di PK, dan defendan ketiga dan keempat tidak berkelayakan sebagai O & G, mahkamah bersetuju dengan pendapat saksi-saksi pakar plaintif-plaintif bahawa kelahiran KJS sepatutnya dijalankan secara caesarean section disebabkan kecacatan kongenital Tay dan bahawa dia sepatutnya dimasukkan ke wad bersalin bukannya PK di mana tidak terdapat O & G berkelayakan (lihat perenggan 69(d)).

(3) Mahkamah mendapati keterangan lisan jururawat-jururawat dan defendan ketiga dan keempat berbeza daripada keterangan objektif dan dokumen-dokumen semasa dan dengan ini, tidak boleh dipercayai. Sebaliknya, keterangan dua saksi pakar yang dipanggil oleh plaintif-plaintif adalah boleh dipercayai. Mereka mengehadkan pendapat mereka kepada fakta-fakta objektif dan dokumen-dokumen semasa dan kepada keseluruhan kebarangkalian tanpa cuba untuk memberikan gambaran salah atau mengelirukan mahkamah (lihat perenggan 65–66).

(4) Pendapat saksi pakar defendan, Dr Angeline, adalah tidak bebas, objektif atau tidak berat sebelah. Terdapat peninggalan dan salah nyata yang ketara dan beliau gagal untuk mempertimbangkan semua fakta material (lihat perenggan 58).]

Notes

For cases on medical negligence, see 12 *Mallal's Digest* (4th Ed, 2011 Reissue) paras 1306–1311.

Cases referred to

Awangku Muhammad Murshyid bin Pg Ali & Anor v Makrami bin Hj Mohd Noor and another appeal [2010] 4 MLJ 662, CA (refd)

Bolam v Friern Hospital Management Committee [1957] 2 All ER 118 (refd)

Bujang bin Mat & Anor v Lai Tzen Hai & Anor [2004] 6 MLJ 376, HC (refd)

Chin Keow v Government of Malaysia & Anor [1967] 2 MLJ 45, PC (refd)

Chung Chu Yin v Dr Jimmy Tang [2012] 2 PIR 27 (refd)

Dato' Tan Heng Chew v Tan Kim Hor and another appeal [2009] 5 MLJ 790, CA (refd)

Elizabeth Choo v Government of Malaysia & Anor [1970] 2 MLJ 171 (refd)

Ervina bt Tatam v Othman b Baba [2008] 1 PIR [34] (refd)

Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593; [2007] 1 CLJ 229, FC (refd)

Foo Sam Ming v Archi Environ Partnership [2004] 1 MLJ 449, CA (refd)

Grace Shipping Inc & Anor v CF Sharp & Co (Malaysia) Pte Ltd [1987] 1 MLJ 257, PC (refd)

HSB Bank Malaysia Bhd v Macquaire Technologies (M) Sdn Bhd [2004] 4 MLJ 398, CA (refd)

J, Re [1991] FCR 193 (refd)

Karuppannan a/l Ramasamy & Anor v Elizabeth Jeramalar Ponnampalam & Ors (Sundaram a/l Marappa Goundan & Anor, interveners and Raya Realti, third party) and another appeal [2010] 1 MLJ 156, FC (refd)

Kow Nan Seng v Nagamah & Ors [1982] 1 MLJ 128, FC (refd)

National Justice Cia Naviera SA v Prudential Assurance Co Ltd, The Ikarian Reefer [1995] 1 Lloyd's Rep 455, CA (refd)

Ng Chul Sia v Maimon bt Ali [1983] 1 MLJ 110 (refd)

Nor Majidah bte Ibrahim v Othman bin Mohamed (2004) MD para 1592 (refd)

Ong Ah Long v Dr S Underwood [1983] 2 MLJ 324, FC (refd)

Rogers v Whitaker (1992) 175 CLR 479, HC (refd)

Shanmugam a/l Gopal v Zinal Abidin bin Nazim & Anor [2003] 3 MLJ 76,HC (refd)

Snell v Farrell (1990) 72 DLR (4th) 289, SC (refd)

Superintendent of Lands & Surveys (4th Div) v Hamit bin Matusin & Ors [1994] 3 MLJ 185, SC (refd)

Tan Cheong Poh & Anor v Teoh Ah Keow [1995] 3 MLJ 89; [1996] 3 CLJ 665, CA (refd)

Tindok Besar Estates Sdn Bhd v Tinjar Co [1979] 2 MLJ 229, FC (refd)

Whitehouse v Jordan & Anor [1980] 1 All ER 650, CA (refd)

Wong Li Fatt William (an infant) v Haidar bte Bolhen & Anor [1994] 2 MLJ 497, HC (refd)

Yang Salbiah & Anor v Jamil bin Harun [1981] 1 MLJ 292, FC (refd)

Yoong Leok Kee Corporation Sdn Bhd v Chin Thong Thai [1981] 2 MLJ 21, FC (refd)

Legislation referred to

Evidence Act 1950 ss 45(1), 101
Rules of Court 2012 O 1A, O 40A r 2

N Jegatheesan (R Jayabalan with him) (John Ang & Jega) for the plaintiffs.
Nik Mohd Noor bin Nik Kar (Farhana Hani bt Md Yazid with him) (Senior Federal Counsel, Attorney General's Chambers) for the defendant's.

Vernon Ong J:

[1] The plaintiffs' claim is for damages for medical negligence on the part of the defendants. It is premised on the second plaintiff of a baby who suffers from cerebral palsy arising from her delivery by her mother, the second plaintiff at the second defendant hospital.

A BRIEF ACCOUNT OF THE SALIENT FACTS

[2] On 7 November 2003, Mdm Tan Pei Hoon the second plaintiff gave birth to Ku Jia Shiuen('KJS') the first plaintiff at the *pusat bersalin* (birthing centre) situated within the compound of the Hospital Sultanah Aminah ('HSA'). The second defendant is the *pengarah* (director) of HSA and the third and fourth defendants are the doctors who attended to the delivery.

[3] Mdm Tan is a small size woman. She was a primigravida (her first pregnancy) when she was admitted to the birthing centre for the delivery of KJS. Subsequent to the birth of KJS who was small in size ('SMA'), she had given birth to two further but normal children also SMA.

[4] During her antenatal period, she was managed and seen by both the nurses at the *klinik kesihatan kerajaan* who provided her with an antenatal book (15–22B1) and by a private O&G specialist one Dr Chu Ah Onn ('PW2').

[5] Her regular antenatal attendance and examination including serial ultra sound scans showed both mother and baby (fetus) as normal at all times.

[6] On 6 November 2003 at about 10.18am, when Mdm Tan was in full term she went to the maternity ward of HSA to give birth. She was examined and referred to the birthing centre for delivery.

[7] The birthing centre is managed by midwives. Doctors from the maternity ward are called to assist in the event of complications in the birth.

[8] On 7 November 2003 during the process of birth, the midwives called one Dr Almei bt Osman ('Dr Almei') the fourth defendant, a houseman to assist in the delivery of KJS. Dr Almei then called for Dr Mohammed Faizal Hashim ('Dr Faizal') the third defendant, a registrar for assistance.

[9] Dr Faizal then performed a vacuum assisted delivery of KJS. According to the neonatal record (5C), the delivery was difficult and the condition of KJS was noted as poor at birth. A diagnosis of KJS suffering from 'RDS' (respiratory distress syndrome) was also noted.

[10] KJS received resuscitation and was sent in an incubator with ventilation of oxygen to the A3 NICU ward of the paediatric unit. Here, she received medical treatment until her discharge on 17 November 2003.

Missing O&G records

[11] All the O&G records, viz, the doctors and the midwives notes,

partogram, etc have not been located. A police report on the missing documents have been made by the defendants on 6 September 2010; but no investigations as to its loss was ever made by either by the *pengarah* or by the police.

[12] Be that as it may, according to the paediatric notes at 7.15am on 7 November 2003, KJS exhibited jitteriness, incomplete moro reflex, cycling movements, lip smacking, starring, jerkiness, fitting, poor sucking and tachypnea (fast breathing).

[13] At the NICU ward the initial diagnosis of KJS's condition was transient tachypnea ('TTN') and the provisional diagnosis was congenital pneumonia (7C). At 8.55am of the same day after admission the provisional diagnosis of neonatal asphyxia ('NNA') was noted (8C). At 4.20pm phenobarbitone (a drug to control seizures) was administered and subsequently phenytoin, a stronger drug was also given.

[14] It is evident from the paediatric notes that NNA was the main provisional diagnosis (19, 21, 23–25, 29, 31, 32, 34, 36, 37, 39, 41–45C). It is also pertinent to add that though meningitis was also considered as a provisional diagnosis, antibiotics to overcome it was given much earlier and on 12 November 2003 (30C) meningitis was considered unlikely. Arterial blood gas count ('ABG') was apparently taken within one hour of birth (11J) and it was agreed that this showed severe metabolic acidosis.

[15] KJS suffers from mixed spastic and dystonic quadriplegic cerebral palsy; this diagnosis has been agreed upon by all the specialists.

THE PLAINTIFF'S CASE

[16] It is the plaintiffs' contention that KJS's condition arises out of hypoxic ischemic encephalopathy ('HIE') suffered by her during the course of her birth (interpartum) at the birthing centre.

[17] The crux of the plaintiffs' case is that KJS's present disability and loss were caused by the defendants' failure during labour to prevent hypoxia and the consequent fetal distress, failing to recognise it in time, failing to take appropriate measures in time, failing to provide suitable/qualified O&G care, failing to provide specialist O&G and failing to provide adequate and immediate after care which could have prevented KJS suffering from HIE and consequent cerebral palsy.

THE DEFENDANTS' DEFENCE

[18] The defendants denied any liability. They say that there was no

negligence on their part.

THE PLAINTIFFS' APPLICATION TO AMEND THE AMENDED STATEMENT OF CLAIM AFTER CLOSE OF CASE BUT BEFORE JUDGMENT

[19] The court also considered the plaintiffs' application to further amend the amended statement of claim after the close of the case but before judgment. The proposed amendments relates to three areas. (1) paras 1 and 5–6 is intended to include the fact that the delivery took place at the BC; this fact is not disputed at the trial; (2) items (a)–(e) of special damages to specify the claim under each item; and (3) item (f) on future rehabilitation costs to include the particulars and estimates. Learned SFC objected to the plaintiffs' application.

Decision on amendment application

[20] It is settled law that amendment can be done at any stage of the proceedings so long as there is no prejudice to the other side that cannot be compensated in costs (*Dato' Tan Heng Chew v Tan Kim Hor and another appeal* [2009] 5 MLJ 790; *Yoong Leok Kee Corporation Sdn Bhd v Chin Thong Thai* [1981] 2 MLJ 21).

[21] The first and second amendments are all based on the evidence at trial. They are merely to specify the amount claimed. The third amendment on future rehabilitation costs is already pleaded. The estimates are based on Dr Malinee's recommendation in her report which was filed and exchanged before trial. The defendants' expert Dr Bahanordin had examined the report when giving his report (exh D5). Dr Malinee was also cross-examined by learned senior federal counsel (SFC) on her recommendations. Dr Bahanordin also give his opinion on Dr Malinee's recommendations and his alternative recommendations. The proposed amendment is to include Dr Malinee's recommendations after taking into account Dr Bahanordin's opinion. Learned counsel for the plaintiffs' submitted that the plaintiffs applied informally to amend in their submission dated 29 November 2012 as it was based on the evidence adduced without objection at the trial. The formal application was filed after receiving the defendants' submission when it was noted that the defendants are taking the issue of failure to plead despite having not raised this objection at the trial when the evidence was produced.

[22] Learned SFC objected to the application on four main grounds. Firstly, there is delay in making the application. There is no prejudice to the defendant because the amendments are based on the evidence at the trial. The application will not delay the determination of the action as the parties have already filed in

their respective submission. In any event, delay alone does not amount to prejudice and cannot defeat an application to amend (*HSB Bank Malaysia Bhd v Macquaire Technologies (M) Sdn Bhd* [2004] 4 MLJ 398 at p 406). Secondly, it is contended that the plaintiffs' solicitors mistake in failing to plead or include them in the earlier application to amend should not be condoned. It is not the function of the court to punish parties for the mistakes in the conduct of their cases by deciding otherwise than in accordance with their rights and in the interest of justice (*Dato' Tan Heng Chew*). Thirdly, learned SFC contended that the proposed application is a tactical manoeuvre. This argument is misplaced as the trial has already been concluded. The plaintiffs are not seeking to adduce any new evidence. The amendments are still based on the same facts and evidence already adduced. Lastly, it was contended that the amendments would necessitate the calling or recalling of witnesses or new witnesses. Since the proposed amendments are based on the evidence already adduced, there is no necessity to recall witnesses or call new witnesses. Essentially, the amendments are based on the evidence of Drs Malinee and Bahanordin; including that of Dr Malinee and Mdm Tan under cross-examination on this issue.

[23] The rules of pleadings are not meant to cause injustice but to avoid surprise. In all the circumstances aforesaid, it cannot be said that the defendants were caught be surprise as the evidence was already presented on the items proposed to be amended without any objection. The fact that the defendants did not object coupled with calling of Dr Bahanordin shows that the defendants were not surprised or prejudiced by the plaintiffs' failure to plead the same. The failure to plead is cured by the failure to object when the evidence was adduced (*Superintendent of Lands & Surveys (4th Div) v Hamit bin Matusin & Ors* [1994] 3 MLJ 185; *Awangku Muhammad Murshyid bin Pg Ali & Anor v Makrami bin Hj Mohd Noor and another appeal* [2010] 4 MLJ 662; *Karuppannan a/l Ramasamy & Anor v Elizabeth* [2010] 1 MLJ 156; O 1A of the Rules of Court 2012). In allowing the amendments, the pleadings will be in line with the evidence presented by the parties at the trial. For the foregoing reasons, the court allowed the amendments.

OVERVIEW OF THE EVIDENCE

[24] Altogether, 17 witnesses give evidence. Six witnesses for the plaintiffs and 11 witnesses for the defendants. They are as follows:

PW1	Chief Inspector Norazlan bin Md Derus
PW2	Dr Chu Ah Onn, O&G Specialist
PW3	Mdm Tan Pei Hoon
PW4	Dato' Dr Ravindran Jegasothy, the plaintiffs' O&G expert

PW5	Dr Malinee Thambyayah, the plaintiffs' paediatric neurosurgeon expert
PW6	Dr Ong Ah How, Radiologist from Puteri Specialist Hospital
DW1	Nurse Kartina binti Tampulan
DW2	Nurse Saadiah binti Hassan
DW3	Nurse Heran binti Mat Adam
DW4	Dr Almei binti Osman
DW5	Dr Mohammed Faizal Hashim
DW6	Nurse Wan Rosmayati
DW7	Faridah Najihah — records officer
DW8	Dr Rooshaimi Merican A Rahim Merican, *Pengarah* HSA
DW9	Dr Angeline Wan Seng Lian, the defendants' expert — neonatalogist
DW10	Dr Bahanordin bin Jaafar, the defendants' rehabilitation expert
DW11	Dr Mohamed Roslan bin Abdul Halim, the defendants' O&G expert

[25] The nurses at the birthing centre who attended to the delivery of KJS give evidence to the effect that the management of labour of Mdm Tan was progressing well with no indication for an urgent delivery, till the end of the second stage of labour when there was a need for intervention. It was at this point that they called for Dr Almei to assist in the delivery. There was sign of fetal distress and there was inadequate effort from Mdm Tan. A vacuum assisted delivery was then performed by Dr Faizal.

[26] Drs Almei and Faizal testified that there was no fetal distress. There was poor maternal effort on the part of Mdm Tan. Vacuum assisted delivery was performed because the cervical os was fully dilated and the fetal head was well down in the pelvis. In answer to the question as to the meaning of the notation in the neonatal record that the 'delivery was: Difficult' they explained that based on their understanding the vacuum assisted delivery was not difficult but the process of delivery was difficult.

Evidence of the experts

[27] Dr Malinee was the only specialist to have examined KJS, taken history and carried out various tests. A summary of her evidence is contained in p 21 of her report (B2). In her examination-in-chief, she also said that she took history from Mdm Tan and carried out various clinical laboratory and other tests including MRI and scan of KJS. From all the above, she concluded that KJS suffered HIE most likely due to birth asphyxia. There were no pre-natal contributing factors. Mdm Tan was in good health. The normal metabolic genetic screening tests show that there are no significant metabolic and genetic causes. The MRI also do not suggest metabolic genetic disorder. Persistent jitteriness, cycling movements, temperature instability and poor sucking reflex

were clear signs of brain injury/HIE. There was significant delay in transferring the infant from the birthing centre to the NICU thereby aggravating the duration of HIE.

[28] Dr Ravindran's report is contained at pp 26–30 of bundle C. In his examination-in-chief, he said that his opinion is limited by the fact the O&G records at the birthing centre is not available. His opinion is based on a review of all the other documents ie the paediatric notes, medical reports and other documents. He said that there were no abnormalities such as intrauterine growth restriction ('IUGR') or any other fetal anomaly was detected during pregnancy care. Ultrasound scan showed normal growth pattern and no abnormalities. According to the infant records the infant was diagnosed with spastic quadriplegic cerebral palsy. There are no indications of antenatal or postnatal causes for cerebral palsy of KJS. The level of care provided to Mdm Tan as she was a high risk patient being in her first pregnancy should have been at specialist level and not at the birthing centre. Pursuant to policy by Ministry of Health, a primigravida has to be admitted to the O&G labour ward for delivery. Furthermore, any deviation from this policy should require permission from the Ministry of Health. It is very likely that in the absence of evidence to the contrary that there was prolonged partial hypoxia in labour that resulted in the development of cerebral palsy in KJS.

[29] In her testimony, Dr Angeline said that KJS was delivered for poor maternal effort and prolonged second stage. However, the records and documents provided to her show that KJS was delivered for fetal distress with poor maternal effort and prolonged second stage (11 and 21B1). Dr Angeline did not record this diagnosis and the notations in her expert report. Dr Angeline's report did not mention the report and antenatal finding of Dr Chu who had found no problems in the health of Mdm Tan or the fetus. In cross-examination, she said that she did not consider Dr Chu's report because 'there is an obstetrics expert who will be looking into the antenatal and obstetrics record.' In her report (para 7 of exh D6) she opined on intrauterine growth restriction (IUGR) as a factor to suggest some chronic hypoxia of antenatal origin. Dr Angeline did not mention about the diagnosis of respiratory distress syndrome of KJS or of the difficult birth nor of the poor condition of KJS at birth (5C). However, at para 3 of her report she relied on the apgar score from the same document (5C) to discount the possibility of HIE. At para 19 of her report under 'facts' and at para 5 under 'opinion' Dr Angeline referred to the original MRI finding (reported as normal) of the Johore Specialist Hospital from Dr Malinee's report (B2) but not the second MRI report of Dr Malinee done on 17 March 2012 which reported as 'due to chronic phase of neonatal asphyxia'. Therefore, Dr Angeline had used this earlier finding to report normality of the brain. In cross-examination, Dr Angeline agreed that MRI findings are important but give no particular reason

as to why she did not mention or comment on the second MRI finding by Dr Malinee. Dr Angeline also did not consider or comment on the NICU ward notes (bundle C) from the first day of admission of KJS diagnosed neonatal asphyxia ('NNA') and where laboratory tests done where the request forms stated the diagnosis as NNA. Dr Angeline also contradicted the diagnosis made by the NICU ward of 'cerebral palsy (spastic quadriplegic) 2° hypoxic ischemic encephalopathy' as noted in their referral letters (12–13B1) when she said that the diagnosis is only 'presumed'. Further, in para 4 of her report she states categorically that under the article annexed to her report the readings do ABG readings do not fulfil the criteria of acute intrapartum hypoxic event. However, in cross-examination, when all the readings were compared with the norm she confirmed that the reading showed severe metabolic acidosis. Then having confirmed in cross-examination this and the fact that the other criteria as shown in box 2 of the criteria (p 1056 of her article) for acute intrapartum hypoxic event has been met in re-examination she then says that the finding of metabolic acidosis is not equivalent to hypoxia alone.

[30] The expert opinion of the defendants' O&G expert Dr Roslan may be summarised as follows. He found no evidence to suggest that there was shortcoming in the management of labour resulting in birth asphyxia leading to hypoxic ischemic encephalopathy causing cerebral palsy. The liquor was not mecomium-stained; there was no fetal tachycardia or bradycardia during the early stage of labour, and the apgar score was seven at five minutes of life. There was spontaneous breathing and the newborn did not require ventilatory support. It was only at the end of the second stage of labour a possible fetal distress which could be a result of hypoxia was detected and it was acted on appropriately by the medical team. A vacuum delivery was performed to expedite delivery. However, under cross-examination, Dr Roslan confirmed that from the available records fetal distress was detected but we do not know whether it was detected in time or if appropriate action was taken in time. He also agreed that the apgar score is subjective and do not indicate clearly the real condition of the newborn baby. He also agreed that in view of the poor condition at birth and diagnosis of RDS being noted in the neonatal record (5C), the apgar score cannot be easily accepted. From the paediatric notes that KJS upon birth was given oxygen with bagging and head box and that KJS had convulsions including NNA. It is significant to note that under cross-examination, Dr Roslan retracted his opinion in his report and confirmed that KJS may well have suffered birth asphyxia leading to HIE and cerebral palsy.

THE LAW ON MEDICAL NEGLIGENCE

Burden of proof

[31] The plaintiff who desires the court to give judgment as to the

defendant's alleged medical negligence bears the burden of proving the facts in support of his case (s 101 of the Evidence Act 1950). In this regard the plaintiff must show that there has been a breach of a specific or general duty that resulted in damage to the plaintiff (*Ng Chul Sia v Maimon bt Ali* [1983] 1 MLJ 110).

Standard of proof

[32] In civil cases the standard of proof is on a balance of probabilities (*Snell v Farrell* (1990) 72 DLR (4th) 289). In law, the standard of proof is satisfied if on the evidence the court considers that it is more likely than not that the facts exist or does not exist. However, in civil suits particularly where allegations of negligence against medical practitioners have been made, such allegations should be assessed on a high degree of probability — the standard of the ordinary skilled medical practitioner exercising and professing to have that special medical skill (*Whitehouse v Jordan & Anor* [1980] 1 All ER 650).

Standard of care

[33] The high degree of probability is inextricably linked to the standard of care to be exercised by a doctor. Whilst it is clear that a doctor owes a duty to exercise reasonable care and skill, what, however, is the standard of reasonable care and skill required of a doctor? The *Bolam* Test has often been cited and accepted as the locus classicus test (*Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; *Chin Keow v Government of Malaysia & Anor* [1967] 2 MLJ 45; *Elizabeth Choo v Government of Malaysia & Anor* [1970] 2 MLJ 171; *Kow Nan Seng v Nagamah & Ors* [1982] 1 MLJ 128). Briefly, the *Bolam* test prescribes two requirements:

(a) the doctor must have acted in accordance with an accepted medical practice; and

(b) the accepted practice must be regarded as proper by a responsible body of medical men in that art.

[34] However, in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229 (FC) the Federal Court adopted the *Rogers v Whitaker* test (*Rogers v Whitaker* (1992) 175 CLR 479) in preference to the *Bolam* test. Accordingly, the standard of care applicable in such cases is not determined solely or primarily by reference to the practice followed or supported by a responsible body of opinion in the medical profession. Thus, while evidence of acceptable medical practice is a useful guide, it is ultimately for the court to adjudicate on what is the appropriate standard of care, drawing upon the totality of the evidence presented.

[35] To establish the claim and to discharge the evidential burden of proof,

A the plaintiffs rely on (i) all the documents filed in court; the expert evidence of Drs Ravindran and Malinee; and (iii) the evidence extracted from the defendants' specialists in their examination.

EXPERT EVIDENCE — SOME BASIC PRINCIPLES

B

[36] In this case, a number of experts were called by the parties for the purpose of obtaining their professional assistance and with the intention of relying on their evidence. It is pertinent to add that the opinion of experts are C relevant facts only insofar as they can assist the court in forming an opinion upon the issues in this case (s 45(1) of the Evidence Act 1950).

[37] It is the primary duty of an expert to assist the court in arriving at the right decision; even if he compromises the case of the party who called him and D is paying for his services. It cannot be overemphasised that the duty to assist the court in arriving at a just decision is paramount. It overrides any obligation to the party from whom the expert has received instructions or by whom he is paid (see O 40A r 2 of the ROC 2012). Therefore, the evidence of an expert should not only be independent but should also be seen to be independent.

E

[38] Apart from the field of law the court itself has no other expertise. For that reason, in cases involving technical, scientific or medical issues which requires specialised knowledge such as forgery, intellectual property, medical F negligence and other like cases the court frequently has to rely on the evidence of experts. What are the duties and responsibilities of expert witnesses? It is useful to consider what Ian Freckelton and Hugh Selby the authors of *Expert Evidence — Law, Practice, Procedure and Advocacy* (Lawbook Co 2005 (3rd Ed)) described as the most important enunciation of the duties and G responsibilities of expert witnesses in the context of *National Justice Cia Naviera SA v Prudential Assurance Co Ltd, The Ikarian Reefer* [1993] 2 Llyod's Rep 68 at pp 81–82 which has since been applied in *National Justice Cia Naviera SA v Prudential Assurance Co Ltd, The Ikarian Reefer* [1995] 1 Lloyd's Rep 455 at p 60:

H

> The duties and responsibilities of expert witnesses in civil cases include the following:
>
> (1) Expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or to I content by the exigencies of litigation (*Whitehouse v Jordan* [1981] 1 WLR 246 at 256–257; 1 All ER 267 at 276 per Lord Wilberforce).
>
> (2) An expert witness should provide independent assistance to the court by way of objective unbiased opinion in relation to matters within his expertise (see *Polivitte Ltd v Commercial Union Assurance Co Plc* [1987] 1

Llyod's Rep 379 at 386 per Garland J and *Re J* [1991] FCR 193 per Cazalet J). An expert witness in the High Court should never assume the role of an advocate.

(3) An expert witness should state the facts or assumptions upon which his conclusions is based. He should not omit to consider material facts which could detract from his concluded opinion (*Re J*).

(4) An expert witness should make it clear when a particular question or issue falls outside his expertise

(5) If an expert's opinion is not properly researched because he considers that insufficient data is available, then this must be stated with an indication that the opinion is no more than a provisional one (*Re J*). In cases where an expert witness who has prepared a report could not assert that the report contained the truth, the whole truth and nothing but the truth without some qualification, the qualification should be stated in the report (*Derby & Co Ltd v Weldon* (1990) Times, 9 November per Staughton LJ).

(6) If, after exchange of reports, an expert witness changes his view on a material matter having read the other side's expert's report or for any other reason, such change of view should be communicated (through legal representatives) to the other side without delay and where appropriate to the court.

[39] As an independent aid to the court, it is therefore essential that an expert witness must possess and retain a standard of absolute personal integrity. In this connection, Cazalet J in *Re J*, said:

> Expert witnesses are in a privileged position: indeed only experts are permitted to give an opinion in evidence. Outside the legal field the court itself has no expertise and for that reason frequently has to rely on the evidence of experts. Such experts must express only opinions which they genuinely hold and which are not biased in favour of one particular party. Opinions can, of course, differ and indeed quite frequently experts who have expressed their objective and honest opinion will differ, but such differences are usually within a legitimate area of disagreement. On occasions, and because they are acting on opposing sides, each may give his opinion from different basic facts. This of itself is likely to produce a divergence.

FINDINGS OF THE COURT

[40] The nurses from the birthing centre who attended to the expectant mother from 6–7 November 2003 give evidence of what took place about nine years ago, from memory; their oral evidence appeared to be vivid and consistent.

[41] Dr Almei was a houseman at the material time. She also give evidence from memory of events that took place ten years ago and from the neonatal record (5C). Dr Faizal was then a registrar in the O&G ward and he also gave

A evidence from memory and from documents (bundle C and B1). He has despite the notation of fetal distress of the fetus in his report (60 and 61C) and the above bundles denied that the fetus suffered from fetal distress ('FD'). The notation 'FD' was made by the birthing centre nursing staff on his instruction.

B **[42]** The paediatric notes (bundle C) reveal that from the outset ie 7.15am on 7 November 2003, KJS exhibited jitteriness, incomplete moro reflex, cycling movements, lip smacking, starring, jerkiness, fitting, poor sucking and tachypnea. All these are signs of seizures or convulsions, a condition that arises because of brain irritation or damage caused either by chemical imbalance, C infection before or after birth or hypoxia during the birth process (intrapartum).

[43] Finally and more particularly the paediatric doctors had subsequently in their referral letters given the diagnosis of KJS's condition as cerebral palsy D (spastic quadriplegia as secondary or arising from HIE; meaning that KJS had suffered from a hypoxic injury (lack of oxygen) during birth.

[44] At the NICU ward the initial diagnosis was TTN and the provisional diagnosis was congenital pneumonia (7C) at 8.55am of the same day after E admission the provisional diagnosis was neonatal asphyxia ('NNA') was made (8C). At 4.20pm not only was NNA the provisional diagnosis but the apgar score given by Dr Almei was also questioned and phenobarbitone was given followed by phenytoin.

F

[45] Thereafter from the paediatric notes it is clear that NNA was the main provisional diagnosis. Furthermore, from date of admission when requesting blood tests from the pathology department the NICU has always given the diagnosis as NNA (39, 45, 51 and 56J). Arterial blood gas ('ABG') count taken G within one hour of birth showed severe metabolic acidosis.

[46] Nurse Kartina wrote down 'FD' on the neonatal record on the instructions of Dr Faizal. However, in his testimony Dr Faizal said that there were no signs of fetal distress when he attended the second stage of labour. H Nurse Wan Rosmayati had noted down that KJS was referred to A3 NICU ward at 7.15am 'with bagging'. However, in her oral evidence, she said that she could have been mistaken in making that note because KJS was referred to A3 NICU Ward without bagging. Dr Almei, Dr Faizal and the nurses testified that there was no fetal distress. Learned senior federal counsel ('SFC') for the I defendants submitted that the oral evidence of Drs Almei and Faizal and the nurses ought to be accepted because they were credible and consistent.

[47] Learned counsel for the plaintiffs submitted that consistency between witnesses is not the test in determining the reliability of their oral evidence

particularly when the witnesses had agreed in cross-examination that they had discussed the case among themselves before giving evidence. They are also giving evidence from their memory on what happened in a delivery nine years ago; when during that month alone there were 216 deliveries. There is inherent unreliability in relying on their oral evidence. More so in the case of Drs Almei and Faizal as they are also the defendants and therefore witnesses in their own cause.

[48] In a situation where there are some contemporaneous records, the oral evidence of the witnesses must be tested. They must be tested against the contemporaneous documents, the undisputed facts and the overall probabilities of the case in order to determine the reliability of the oral evidence.

[49] Dr Almei had noted that the delivery was difficult and condition at birth poor and that KJS needed resuscitation at birth and having no cry (5C). Her evidence in court is inconsistent with her own notation on this point. After Dr Almei's resuscitation and admission of KJS to NICU KJS exhibited signs of seizures or convulsions and needed to be given oxygen and to be placed in an incubator (16J; 6–33C). KJS suffered from severe metabolic acidosis as shown by the laboratory results of blood taken at 7am (11J); this finding is supported by the evidence of Dr Ravindran, Dr Malinee and Dr Angeline under cross-examination and re-examination. The details of delivery and admission (60–61C) 'FD' with 'poor maternal effort and prolonged second stage' is recorded by the midwives on Dr Faizal's instructions. Dr Faizal did not produce any evidence to explain or justify why his instructions to the midwives on the notations were wrong. With respect, the court must treat Dr Faizal's attempt to discount contemporaneous documents with caution. His attempt to explain away the so-called mistake is unconvincing. On the evidence as a whole, the court is not satisfied that Dr Faizal's oral evidence is consistent with the inherent probabilities of the case.

[50] Applying the principles enunciated in the authorities cited above, the court also evaluated Dr Angeline's evidence against the contemporaneous documents to determine whether it is independent, objective and unbiased.

[51] In para 2 of her opinion under 'facts', she states that KJS was delivered for poor maternal effort and prolonged second stage. However, from the records and documents provided to her, it is clear that KJS was delivered for fetal distress with poor maternal effort and prolonged second stage (11 and 21B1). Dr Angeline failed to record this diagnosis by Dr Almei and the notations. Fetal distress is defined as compromise of a fetus during the antepartum (before birth) period or intrapartum period (during the birth process). The term fetal distress is commonly used to describe fetal hypoxia

(low oxygen level in the fetus) which result in fetal damage or death. The fact that there was fetal distress is a significant and material fact which ought to have been noted.

[52] Secondly, Dr Angeline also failed to mention or consider the report and antenatal findings of Dr Chu who had found no problems in the health of Mdm Tan or the fetus. Strangely, when asked in cross-examination why she had failed to mention Dr Chu's findings, she replied 'there is an obstetric expert who will be looking into the antenatal and obstetrics record'. Yet she had in para 7 of exh. D6 given her opinion on intrauterine growth restriction ('IUGR') as a factor to suggest some chronic hypoxia of antenatal origin.

[53] Thirdly, Dr Angeline failed to mention anywhere in exh D6 of the diagnosis of respiratory distress syndrome of KJS or of difficult birth nor of the poor condition of KJS at birth as shown in p 5 of bundle C. Yet at para 3 of exh D6, she cherry picked the apgar score from this same p 5 of bundle C to discount the possibility of HIE.

[54] Fourthly, at para 19 under 'facts' and para 5 under 'opinion' on exh D6, Dr Angeline again picks the original MRI finding of (reported as normal) the Johore Specialist Hospital from Dr Malinee's report (B2) but not the second MRI report of Dr Malinee done on 17 March 2012 reported as 'due to chronic phase of neonatal asphyxia'. Dr Angeline uses this earlier finding to report normality of the brain. In cross-examination Dr Angeline agreed that the MRI findings are important facts upon which she relies on. Yet, when asked why she omitted mention or comment on the second MRI finding by Dr Malinee on 17 March 2011, her answer was 'no particular reason'. Her subsequent answer in re-examination is also without basis and makes a mockery of this answer.

[55] Fifthly, Dr Angeline failed to consider the diagnosis that was recorded in the NICU ward (bundle C) beginning from the first day of admission of KJS being diagnosed with neonatal asphyxia ('NNA'). They had also had laboratory tests done within the request forms stated the diagnosis as NNA (11 – 37C; 3, 5, 6, 7, 45, 51 and 39J).

[56] Sixth the NICU ward had subsequently in their referral letters (12 and 13B1) made a diagnosis of spastic quadriplegic cerebral palsy 2° HIE. Yet Dr Angeline in her report under 'facts' misrepresented this diagnosis as 'presumed' (para 20 exh D6).

[57] Seventh, under para 4 of her opinion in exh D6, Dr Angeline states categorically that under the article annexed to her report the readings do not fulfil the criteria of acute intrapartum hypoxic event. Yet in cross-examination when all the readings were compared with the norm she confirmed that the

reading showed severe metabolic acidosis. Then having confirmed in cross-examination this and the fact that the other criteria as shown in box 2 of the criteria (p 1056 of her article) for acute intrapartum hypoxic event has been met in re-examination she completely forgets this very criteria she propounded and says that the finding of metabolic acidosis is not equivalent to hypoxia alone.

[58] For the foregoing reasons, it is clear that the defendant's expert Dr Angeline in giving her opinion is neither independent, objective or unbiased. There were glaring omissions and misrepresentations. Dr Angeline also failed to consider all the material facts.

[59] In cross-examination Dr Mohd Roslan confirmed that from the available records fetal distress was detected but we do not know if it was detected in time or if appropriate action was taken in time.

[60] The statement by Dr Faizal that his report on fetal distress (11B1) and the notations of fetal distress ('FD') (21B1; 60 and 61C) which was made on his instructions should be discarded cannot be accepted. Firstly, it is a self-serving contention and runs counter to the contemporaneous records and documents. Medical records and reports that are well kept are the hallmark of a good medical practice. Such records should be accurate, legible, comprehensive and up-to-date, and contribute to easy recall of patient information for continuity and follow-up of patients, as well as for future reference. This well settled principles governing medical practitioners is encapsulated in a booklet entitled 'Good Medical Practice' issued by the Malaysian Medical Council ('MMC'). It serves as a guide to the medical practitioners to meet the standard of case professionalism and professional obligations expected of medical practitioners as set out by the MMC. The passage on 'On maintaining good Patient Records' is worth noting and is reproduced below:

> Medical Records and Reports
>
> In general, well-kept Medical Records are the hallmark of a good medical practice. Patient cards should record all relevant information, physical findings and diagnosis in the course of patient management. Such records should be accurate, legible, comprehensive and up-to-date, and contribute to easy recall of patient information for continuity and follow-up of patients, as well as for future reference such as preparing reports.
>
> Investigations and treatment should be recorded in detail, and in the case of invasive procedures, the indications for, and the nature of, the procedures, must be clearly documented. Properly justified procedures can be defended by peers in the event of conflict or litigation, but when the clinical notes are sketchy, poorly made out, illegible, vague, ambiguous and superimposed with deletions and corrections, this may be difficult.

A Similarly, notes and records relating to operations and invasive procedures should be written clearly, with attention to indications, findings, relevant details, difficulties encountered and the measures taken.

Notes once made out should not be erased or altered, or new words inserted after a lapse of time, as these may indicate defensive action by the doctor in the event of
B unexpected eventualities in the course of patient management.

[61] Dr Faizal, Dr Almei and the midwives from the birthing centre who attended to the expectant Mdm Tan from 6–7 November 2003 gave evidence from memory. Given these circumstances, what is the weight to be accorded to
C their evidence?

[62] In *Foo Sam Ming v Archi Environ Partnership* [2004] 1 MLJ 449 (CA) the contemporary documentary evidence in the appellant's own hand contradicted his viva voce testimony. The Court of Appeal agreed with the trial
D judge who preferred the contemporaneous documents to the rather tenuous and tardy and unconvincing oral explanations given by the appellants on oath. The Court of Appeal cited two authorities which supported the trial judge's approach.

E

[63] The first is *Tindok Besar Estates Sdn Bhd v Tinjar Co* [1979] 2 MLJ 229 where Chang Min Tat FJ said at p 234:

Nevertheless, the learned trial judge expressed himself to be completely satisfied with the veracity of the respondent's witness and their evidence. He purported to
F come to certain findings of fact on the oral evidence but did not notice or consider that the respondent's oral evidence openly clashed with its contemporaneous documentary evidence. For myself, I rely in the acts and deeds of a witness which are contemporaneous with the event and to draw the reasonable inferences from them than to believe their subsequent recollection or version of it, particularly if he is a
G witness with a purpose of his own to serve and if it did not account for the statements in his documents and writings. Judicial perception of the evidence requires that the oral evidence be critically tested against the whole of the other evidence and the circumstances of the case. Plausibility should never be mistaken for veracity.

H **[64]** The second case is *Grace Shipping Inc & Anor v CF Sharp & Company (Malaysia) Pte Ltd* [1987] 1 MLJ 257, where Lord Goff of Chieveley said at p 265:

And it is not to be forgotten that, in the present case, the judge was faced with the
I task of assessing the evidence of witnesses about telephone conversations which had taken place over five years before. In such a case, memories may well be unreliable; and it is of crucial importance for the judge to have regard to the contemporary documents and to the overall probabilities. In this connection, Their Lordships wish to endorse a passage from a judgment of one of their number in *The Ocean Frost; Armagas Limited v Mundogas SA* [1985] 1 Llyod's Rep 1 when he said at p 57:

> Speaking from my own experience, I have found it essential in cases of fraud, when considering the credibility of witnesses, always to test their veracity by reference to the objective facts proved independently of their testimony, in particular by reference to the documents in the case, and also to pay particular regard to their motives and to the overall probabilities. It is frequently very difficult to tell whether a witness is telling the truth or not; and where there is a conflict of evidence such as there was in the present case, reference to the objective facts and documents, to the witnesses' motives, and to the overall probabilities, can be of very great assistance to a judge in ascertaining the truth.
>
> That observation is, in Their Lordships' opinion, equally apposite in a case where the evidence of the witnesses is likely to be unreliable; and it is to be remembered that in commercial cases, such as the present, there is usually a substantial body of contemporary documentary evidence.

[65] Whilst not doubting the honesty or credibility of the nurses, Dr Almei and Dr Faizal, the court is concerned about the accuracy and correctness of their recollection of the events. According to exh D11, it is evident that in the month of November 2003, there were 216 births at the birthing centre alone. More significantly, the nurses admitted that they had discussed the case among themselves prior to giving evidence. That admission suggests that their recollection of the events could have been incomplete, poor or inconsistent. There is every likelihood their evidence may be lacking in veracity and accuracy due to the long passage of time. This observation is fortified by the fact that their oral evidence is not consistent with the notation in the contemporaneous documents; in particular the neonatal record (5C) and the nursing notes (6C); instances of inconsistencies were cited above. In all the circumstances, the court finds that the evidence of the nurses, Drs Almei and Faizal depart from the objective evidence and the contemporaneous documents. Accordingly, their oral evidence as a whole is unreliable and is of no assistance to the court.

[66] On the other hand, the court found Dr Ravindran and Dr Malinee to be credible, independent, unbiased and objective. They confined their opinion to the objective facts and contemporaneous documents and to the overall probabilities. They did not omit any material facts; nor did they attempt to misrepresent or mislead the court. Their evidence were consistent, concise and clear. In the final analysis, the court prefers the opinions of Dr Ravindran and Dr Malinee which are based on the objective facts and contemporaneous documents.

[67] It is pertinent to note the salient points in Dr Ravindran's opinion: Two areas of concern:

(a) Mdm Tan who was a primigravida was admitted to the BC where is supposed to be a low risk delivery centre. There are no specialists in this area and care would be provided generally at the midwives level. When

problems arise, the medical officer would be called and the patient may be transferred to the labour ward in the hospital. This was not an appropriate area for this mother to be admitted. It is possible that lack of oxygen during labour was not recognised and attended to promptly enough in this mother due to the fact that she was at the BC; and

(b) There are lack of details as to who resuscitated the baby at delivery when the apgar score was noted to be 7 at 1 minute and 7 at 5 minutes. The baby was brought in an incubator to the special care nursery at 7:15am, nearly 1 hour after delivery and the baby was seen by a medical officer at 8:00am, nearly 2 hours later. This was not appropriate for an ill baby.

Conclusion

(1) It is my opinion that the mother who was in her first pregnancy had a fairly normal antenatal course of events in her pregnancy. She did not have any evidence of illnesses that would have caused the development of cerebral palsy in her child.

(2) It is without doubt that the child born in this pregnancy had developed spastic quadriplegic cerebral palsy. I am of the opinion that this mother was cared for in labour in an inappropriate place where no specialist was immediately available if she developed problems in labour. The absence of medical records severely constrains the formulation of an opinion that can be substantiated by evidence from the medical records.

(3) However, *it is evident that there was fetal distress and the baby was delivered by vacuum delivery from the medical report provided. It is therefore very likely, in the absence of evidence to the contrary, that there was prolonged partial hypoxia in labour of at least one hour that resulted in the development of cerebral palsy in this infant.*

(4) There is also a two hour gap in the records of the care provided to the infant after delivery where hypoxia could have continued and aggravated the neonatal condition resulting in the child currently developing cerebral palsy. (Emphasis added.)

[68] It is equally pertinent to note the salient points in Dr Malines's opinion:

(a) examinations and investigations have revealed a profoundly severe brain injury due to hypoxic ischemic encephalopathy ('HIE');

(b) it is clear that the infant suffered from HIE, most likely due to a perinatal etiology ie, birth asphyxia. There were no prenatal contributing factors;

(c) the mother was in good health. If at all, given the fact that she had a congenital right knee deformity, she should not have been allowed a normal delivery and be put through a lithotomy position thereby contributing to further poor maternal effort. The mother cannot

flex/bend her right knee at all. An elective caesarean section should have been planned (as done for her subsequent two pregnancies);

(d) there are no significant metabolic or genet causes as evident by the normal metabolic-genetic screening tests done for KJS in March 2011;

(e) the apgar score must have been underscored because the infant was described as being in a 'poor condition' at birth. This impression was also shared and documented by the treating doctors during the neonatal period (11C);

(f) there was significant delay in transferring the infant from the BC from the moment of delivery at 6.10am to NICU at 7.15am, thereby aggravating the duration of HIE;

(g) there was also delay in recognition and treatment of the neonatal seizures and anti-convulsant drugs (phenobarbitone and phenytoin) were only commenced at 16 hours and 42 hours of life respectively. Based on the given clinical information, the infant suffered from at least stage two perinatal HIE. Persistent jitteriness, cycling movements, temperature instability and poor sucking reflex were clear signs of brain injury/HIE. Cerebral resuscitation with early elective intubation and ventilation should have been carried out; and

(h) it is very likely, in the absence of evidence to the contrary, that there was prolonged partial hypoxia in labour of at least one hour or even more that resulted in the development of cerebral palsy in this infant.

ISSUES FOR DETERMINATION

[69] The court will now address the four agreed principal issues for determination which are as follows:

(a) *whether the defendants are liable for the spastic quadripiegia secondary to HIE suffered by KJS?*
In the light of the above findings, the court is satisfied that on the balance of probabilities the defendants are liable for the spastic quadripiegia secondary to HIE suffered by KJS. The question is answered in the affirmative;

(b) *whether the defendants should have carried out a caesarean section in preference to vacuum extraction under the circumstances; or whether the defendants should have carried out the vacuum extraction in time to avoid serious fetal distress?*
This issue was abandoned by the plaintiffs;

(c) *whether the defendants have provided appropriate immediate after care after the delivery of KJS in order to avoid KJS's neonatal condition from aggravating into cerebral palsy?*

The court is satisfied that on the balance of probabilities that the defendants failed to provide the appropriate immediate after care; which delay contributed to aggravation of HIE and the development of cerebral palsy in KJS; and

(d) *whether the defendants failed to ensure that the qualified and suitable O&G is available to manage the plaintiffs?*

It is not disputed that there are no qualified and suitable O&G available at the BC. Dr Almei was a houseman; she was not a qualified O&G. Dr Faizal was also not a qualified O&G. In all the circumstances, the court agrees with the opinion of Dr Malinee that Mdm Tan ought to have been delivered KJS through caesarean section due to her congenital knee deformity. If so, Mdm Tan ought to have been admitted to the labour ward instead of to the BC where there are no qualified O&G on hand. Accordingly, the question is answered in the affirmative.

QUANTUM OF DAMAGES

[70] It is settled law that damages in tort are not meant to be punitive; neither a reward. Damages are meant to be a form of compensation that will give the injured party reparation for the wrongful act so far as money can compensate. It is not meant to enrich the injured party. Therefore, the compensation must by fair, reasonable and adequate but not excessive (*Yang Salbiah & Anor v Jamil bin Harun* [1981] 1 MLJ 292) The aim is to put the injured party back as it were, as far as possible to his original position prior to the tortuous act which caused the damage (*Shanmugam a/l Gopal v Zinal Abidin bin Nazim & Anor* [2003] 3 MLJ 76; *Ong Ah Long v Dr S Underwood* [1983] 2 MLJ 324 (FC)).

General damages (for pain and suffering and loss of amenities)

[71] In assessing the quantum of general damages, the court will have regard to the following factors:

(a) the fact that KJS's condition is quadriplegic cerebral palsy with profound global development delay;

(b) the fact that KJS is totally dependent on her family since birth for herself care activities;

(c) the fact that KJS is consigned to an immobile life, physically and

mentally retarded, has no chance of being educated or trained, will never live the life of a normal child or adult; and

(d) the fact that KJS will have a shortened life span of between 30–35 years.

Learned counsel for the plaintiffs (citing *Nor Majidah bte Ibrahim v Othman bin Mohamed* (2004) MD para 1592; *Ervina bt Tatam v Othman b Baba* [2008] 1 PIR [34]; *Chung Chu Yin v Dr Jimmy Tang* [2012] 2 PIR [27]) submitted that RM550,000 as a reasonable award. Learned SFC (citing *Wong Li Fatt William (an infant) v Haidar bte Bolhen & Anor* [1994] 2 MLJ 497; *Tan Cheong Poh & Anor v Teoh Ah Keow* [1995] 3 MLJ 89; [1996] 3 CLJ 665) submitted RM200,000 as a reasonable figure. All the cases cited by the parties may be distinguished on the facts insofar as they relate to KJS's condition.

[72] It is also necessary to note the plaintiffs' claim is not limited to only an award for general damages. The award for pain and suffering and loss of amenities must also be considered in the light of the plaintiffs' claim for special damages below. Accordingly, after having regard to the cases cited and to the particular circumstances of this case, the court awards the sum of RM350,000 as general damages.

Special damages

[73] In assessing the quantum of special damages, the court must take into account the life expectancy of KJS. Dr Malinee estimated a minimum of 20 years and maximum of 40–50 years. Dr Bahanordin estimated KJS's life expectancy of between 17–20 years. However, under cross-examination Dr Bahanordin agreed with the fact that KJS was well taken care of and quite rightly revised his original opinion to between 30–35 years. In that light, learned counsel for the plaintiffs suggested a conservative life expectancy of 30 years. At the trial, the court observed that notwithstanding her mental and physical condition, KJS appears to have been very well taken care of by her parents. They displayed much tender love, care and affection to KJS; which seems to be reciprocated by KJS toward her parents. In all the circumstances, the court finds that a period of 35 years is a more reasonable estimate of KJS's life expectancy. As there should be a discount of 1/3 for contingencies (see *Bujang bin Mat & Anor v Lai Tzen Hai & Anor* [2004] 6 MLJ 376), the multiplier for general damages should be 18; the computation is as follows:

35 (life expectancy) — 9 (present age) = 26

Less 1/3 contingency 26/3 = 8.666

26-8 = 18

(a) *Nursing care.*

In the circumstances, KJS requires nursing care. A sum of RM1,000 per month as the costs of a domestic maid for nursing care is reasonable. Accordingly, nursing care at RM1,000 a month for 18 years would come to RM216,000;

(b) *Physiotherapy.*

The claim for costs of massage and acupuncture is withdrawn; leaving only the claim for physiotherapy. Both Drs Malinee and Bahanordin agree that physiotherapy is necessary to prevent joint contractures deformity. KJS undergoes physiotherapy every month at the Hospital Sultan Ismail and weekly at Kota Tinggi District Hospital. She is given home physiotherapy twice a day by her parents. Dr Malinee estimates the costs of home based physiotherapy at RM150–RM200 per session is fair and within range of current physiotherapist's charges. Dr Bahanordin agrees with Dr Malinee's estimation.

However, there is nothing to show that the present arrangements is not feasible or cannot be continued. In the circumstances, the plaintiffs' suggestion of four sessions per week is unreasonable; with the aid of a domestic maid for KJS's exclusive nursing care who can be trained to administer home based physiotherapy, one session per week (four days a month) of physiotherapy should be adequate for KJS's needs. The quantum for physiotherapy is as follows:

RM150 x 4 days a month = RM600 a month.

For 18 years — RM600 x 12 x 18 = RM129,600;

(c) *Transport expenses for rehabilitation exercises.*

The plaintiffs are not seeking transport expenses for the physiotherapy and occupational therapy as they are asking for home therapies. As such, there is no award under this item;

(d) *Costs of extra food and nourishment.*

In all the circumstances, a sum of RM100 per month for the costs of milk for KJS is reasonable. At RM100 per month for 18 years — RM100 x 12 x 18 = RM21,600;

(e) *Costs of hygiene pads.*

Since KJS has no control over her bowel or bladder, she is on hygiene pads constantly. At an average consumption of between 6–9 pieces per day, at a cost of RM33 per packet, the average monthly costs is RM150 a month. In the premises, RM150 x 12 x 18 = RM32,400; and

(f) *Future rehabilitation costs.*

Based on the estimates prepared by Drs Malinee and Bahanordin, the plaintiff's claim are allowed in the following items:

(i) *Outpatient medical and surgical consultation.*

Clinical consultation every four months is reasonable to protect KJS against any further complications. At RM250 per visit for three visits per annum for 18 years, the amount comes to RM 13,500;

(ii) *Inpatient medical care to treat epilepticus.*
KJS suffers from epileptic fits. This item is in the event that the epileptic condition aggravates in the future. Dr Malinee estimated RM10,000–RM15,000 per admission. Dr Bahanordin did not challenge this estimation. In the premises, an award of RM20,000 for two admissions is reasonable;

(iii) *Botox treatment for spasticity/dystonia, drooling.*
Dr Bahanordin agreed to the need for botox treatment every six months, Dr Malinee estimated RM12,000–RM20,000pa. At RM12,000pa for 18 years the amount awarded is RM216,000;

(iv) *Surgery for joint contractures (tenotomy).*
Dr Malinee opines that KJS will have joint contractures in time and will require operation estimated at between RM5,000–RM10,000. An award of RM7,000 is reasonable in this instance;

(v) *Spinal surgery for scoliosis.*
Dr Malinee noted there was curvature of the spine. The curvature will be more angulated and there will be a need for surgery as she grows — estimated at RM50,000–RM80,000. In the circumstances, the sum of RM50,000 is a reasonable sum;

(vi) *Specialised routine tests.*
Dr Malinee has recommended routine diagnostic tests to be done ie, EEG, MR (and X-ray pelvis and spine to assess the progress of KJS's condition regularly and precautionary.
EEG tests at RM400 per visit for 18 years, the amount is RM7,200.
MRI at RM2,000 per session for 18 years is RM36,000.
X-ray pelvis and spine at RM200pa for 18 years is RM3,600;

(vii) *Occupational therapy.*
Dr Malinee also recommended KJS undergo occupational therapy; a home based therapy is RM150 per session. Dr Bahanordin agreed that occupational therapy is necessary to optimise KJS's potential and to prevent further complication. He also agreed that Dr Malinee's estimation of the costs is a fair estimation. However, the court feels that one session a week is adequate taking in consideration that there will also be home based physiotherapy. At one session per week: RM150 x 4 days a month = RM600 a month. For 18 years — RM600 x 12 x 18 = RM129,600, and

(viii) *Rehabilitation equipments.*

Both Drs Malinee and Bahanordin agreed that rehabilitation has to consider the patient's needs and minimisation of the caregivers' burden;

(1) *Wheelchair.*
The court accepts Dr Bahanordin's suggestion that a manual tilt-in-space wheelchair of about RM5,000 is reasonable with a lifespan of five years. Therefore, for 18 years, four replacements will be needed — RM5,000 x 4 = RM20,000. Including RM500 per year for maintenance, the total for this item is RM20,000 + RM9,000 (maintenance for 18 years) = RM29,000;

(2) *Motorised wheelchair.*
In all the circumstances, the court does not think that a motorised wheelchair is necessary;

(3) *Standing frame (manual tilt table).*
The court accepts Dr Bahanordin's recommendation of RM2,500 with lifespan of five years. At 18 years, RM2,500 x 4 replacements = RM10,000;

(4) *Postural chair.*
The court accepts Dr Bahanordin's recommendation of tumble form seating system at RM2,500 and postural chair at RM3,000 with five years life span. At 18 years, RM5,500 x 4 replacements = RM22,000;

(5) *Ankle foot orthosis.*
Both Drs Malinee and Bahanordin have recommended this item. The court award RM600 to changed every two years: RM600 x 9 = RM5,400;

(6) *Car seat.*
A sum of RM500 is reasonable;

(7) *Home therapy aids.*
The court accepts Dr Bahanordin's suggestion of exercise balls and mats at RM2,000 with ten years life span. Accordingly, RM2,000 x 2 = RM4,000;

(8) *Spinal brace for scoliosis.*
Both Drs Malinee and Bahanordin agreed on the need for spinal braces. Allowing for RM3,000 and four replacements over 18 years, the amount allowed is RM12,000;

(9) *Assists in toileting/bathing.*

The court accept Dr Bahanordin's recommendation. At RM3,000 x 4 replacements, the amount allowed is RM12,000;

(10) *Transportation needs.*
The court also accepts Dr Bahanordin's recommendation of a hoist at RM5,000 with ten years lifespan to transfer KJS and a mounted car lift and wheelchair anchoring system at RM20,000 with ten years lifespan to transport the wheelchair. The amount allowed is: Hoist — RM5,000 x 2 replacements = RM10,000.
Mounted car lift, etc — RM20,000 x 2 replacements = RM40,000;

(11) *Home modifications.*
The court accepts Dr Bahanordin's estimate of RM50,000 for modifications to the bathroom, installation of ramps for the wheelchair. Accordingly, the amount allowed is RM50,000; and

(12) *Costs of medical and specialist reports.*
As the reports and receipts have been produced, the amount of RM29,559.40 is allowed.
The total amount allowed for general and special damages is RM1,456,959.40.

[74] Interest on general damages and special damages as prayed and amended.

[75] Fixed costs of RM150,000.

Order accordingly.

Reported by Ashok Kumar